***PLEASE GIVE THIS COMPLETED FORM TO THE NURSE***
***AFTER YOU ARE CALLED BACK***

PATIENT NAME: _____

***CURRENT PROBLEMS** ☐ NO PROBLEMS TODAY - ROUTINE VISIT

| REASON FOR YOUR VISIT TODAY | INDICATE AFFECTED SIDE (IF APPLICABLE) | STATUS (NEW OR ONGOING PROBLEM) | DATE OF ONSET |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***SURGICAL HISTORY** ☐ NO HISTORY OF SURGERIES

| TYPE OF PROCEDURE | PROCEDURE DATE |
|---|---|
| | |
| | |
| | |

***MEDICATIONS** ☐ NO MEDICATIONS TAKEN

| NAME OF MEDICATION | DOSE |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

PHARMACY OF CHOICE: _____

***VACCINATIONS** ☐ NO HISTORY OF VACCINATIONS

| TYPE | DATE GIVEN | CLINIC/FACILITY WHERE ADMINISTERED |
|---|---|---|
| | | |
| | | |
| | | |

***ALLERGIES** ☐ NO KNOWN ALLERGIES

| ALLERGIC TO/ALLERGEN | TYPE OF REACTION | SEVERITY (MILD,MODERATE,SEVERE) | DATE OF ONSET |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

***SOCIAL HISTORY (CIRCLE ALL THAT APPLY)**

(CIRCLE SMOKING STATUS): NEVER SMOKED - FORMER SMOKER - CURRENT EVERY DAY SMOKER - CURRENT SOME DAY SMOKER - UNKNOWN OTHER TOBACCO USE: YES/NO
SMOKED OR TOBACCO USE SINCE AGE: _____ YEARS OF USE:_____ ALCOHOL USE: YES/NO HOW OFTEN DO YOU USE ALCOHOL: EVERY DAY/SOCIALLY
DIET:_____ CAFFEINE USE: YES/NO ADVANCE DIRECTIVE: YES/NO CURRENTLY PREGNANT: YES/NO
CHANGES IN FAMILY OR SOCIAL SITUATION: YES/NO LEGALLY BLIND: YES/NO HARD OF HEARING OR DEAF: YES/NO SEAT BELT OR CAR SEAT USED ROUTINELY: YES/NO
MOSQUITO REPELLENT USED ROUTINELY: YES/NO SUNSCREEN USED ROUTINELY: YES/NO SMOKE DETECTORS IN HOME: YES/NO
NUMBER OF SIBLINGS: _____ POOL EXPOSURE (FOR CHILDREN): YES/NO SPORTING ACTIVITIES:_____

***USE BACK OF FORM FOR MORE COMMENTS IF NEEDED***

***PLEASE GIVE THIS COMPLETED FORM TO THE NURSE***
***AFTER YOU ARE CALLED BACK***

PATIENT NAME: _____

***PAST MEDICAL HISTORY (CIRCLE ALL THAT APPLY)** ☐ NO TO ALL

ADD/ADHD
ABNORMAL PAP
ABUSE/DOMESTIC VIOLENCE
ACID REFLUX (GERD)
ACNE
ALLERGIES
ANEMIA
ANESTHESIA COMPLICATIONS
ANXIETY DISORDER
ARTHRITIS
ASTHMA
AUTISM SPECTRUM DISORDER
AUTOIMMUNE DISORDER
BEDWETTING
BIRTH DEFECTS/INHERITED DISEASE
BLADDER PROBLEMS
BLOOD DISEASES
BLOOD TRANSFUSIONS
BREAST CANCER
BREAST PROBLEM
COPD
CANCER
CHICKEN POX
CONGENITAL ANOMALIES
CONSTIPATION
CORONARY ARTERY DISEASE
DEPRESSION
DEVELOPMENTAL DISORDERS
DIABETES
DIVERTICULITIS
EAR OR HEARING PROBLEMS
EATING DISORDER
ECZEMA
ENDOMETRIOSIS
FIBROMYLAGIA
GI PROBLEMS
GYN PROBLEMS
GOUT
HIV
HEAD INJURY/CONCUSSION
HEADACHES/MIGRAINES
HEART DISEASE
HEART PROBLEMS/MURMUR
HEPATITIS
HIGH BLOOD PRESSURE
HIGH CHOLESTEROL
HOSPITAL ADMISSION
HYPERTHYROIDISM
INFERTILITY
KIDNEY DISEASE/KIDNEY STONES
LIVER DISEASE
LUNG DISEASE
MENTAL ILLNESS
MUSCLE PROBLEMS
JOINT/BONE PROBLEMS
NEUROLOGICAL DISORDER
OSTEOPOROSIS
OVARIAN CANCER
PHLEBITIS
POLYPS
PRE-ECLAMPSIA
PSYCHIATRIC ILLNESS
PULMONARY EMBOLISM
STD
SEIZURES/EPILEPSY
SKIN PROBLEMS
STROKE
THROMBOPHILIAS
THYROID PROBLEMS
TUBERCULOSIS
VARICOSITIES (VARICOSE VEINS)
VISION OR EYE PROBLEMS
IF OTHER AND NOT LISTED, PLEASE WRITE BELOW:

***FAMILY HISTORY** ☐ UNKNOWN

| RELATION | PROBLEM | ONSET AGE | DIED AT AGE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***PRENATAL AND BIRTH HISTORIES (IF APPLICABLE)**

NUMBER OF PREGNANCIES_____ NUMBER OF LIVE BIRTHS_____

| PROBLEM | DATE |
|---|---|
| | |
| | |
| | |
| | |
| | |

***OTHER PHYSICIANS OR SPECIALISTS YOU ARE CURRENTLY UNDER THE CARE OF**

| NAME | SPECIALITY | PHONE |
|---|---|---|
| | | |
| | | |
| | | |

***USE BACK OF FORM FOR MORE COMMENTS IF NEEDED***

Yoakum Family Practice
at Yoakum Community Hospital

# Patient Registration

| **Patient Information** | | | |
|---|---|---|---|
| Last Name | First Name | | Middle Initial |
| Mailing Address | | City, State | Zip |
| Physical Address | | City, State | Zip |
| Home Phone Number | Social Security Number | Date of Birth | Age |
| Cell Phone Number | E-Mail | Marital Status: | |
| In Case of an Emergency | | Phone Number | Relationship to Patient |
| How did you hear about our office? | | Referring Physician (if applicable) | |
| Is this:<br>[ ] Injury [ ] or Illness | Work Related?<br>[ ] Yes [ ] No | Auto Accident Related?<br>[ ] Yes [ ] No | Other Accident Related?<br>[ ] Yes [ ] No |
| Do you have an Advance Directive or Living Will?<br>[ ] Yes [ ] No | | Sex : [ ] Male [ ] Female | |
| Responsible Party Name: | | Responsible Party Date of Birth: | |
| Pharmacy Name | Address | Phone Number | |
| **Insurance Coverage # 1** | | | |
| Insurance Company Name | Employer's Name | Employer's Phone Number | |
| ID Number | Group Number | Insurance Company Phone Number | |
| Policy Holder Name | Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child | | |
| Policyholder Date of Birth: | Policyholder SSN: | | |
| Insurance Address | City | State | Zip |

Yoakum Family Practice
at Yoakum Community Hospital

# Patient Registration

| Insurance Coverage # 2 | | | |
|---|---|---|---|
| Insurance Company Name | Employer's Name | Employer's Phone Number | |
| ID Number | Group Number | Insurance Company Phone Number | |
| Policy Holder Name | Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child | | |
| Insurance Address | City | State | Zip |

**ASSIGNMENT AND RELEASE**: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release all information contained in my financial and medical records to my insurance company or health plan, or any other person or entity that is responsible for paying or processing for payment any portion of my bill. I understand that I am totally responsible for payment of all fees and services rendered. I permit a copy of this authorization to use in place of the original.

**MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE:** I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Yoakum Family Practice. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

**NO SHOW POLICY:** After three no-shows to your appointment, you are subject to be terminated as a patient of Yoakum Family Practice. Please notify us 24 hours in advance if you need to cancel or reschedule your appointment.

**FINANCIAL OBLIGATION:** I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am totally fully responsible for payment of all fees and services rendered, regardless of insurance coverage or other responsibilities and ultimately responsible for payment in full if my insurance company does not pay in a timely manner.

**CONSENT FOR TREATMENT:** I hereby authorize the physician, nurses, medical assistants, and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** By signing below, you indicate that Yoakum Family Practice has provided this Notice of Privacy Practices to you.

**ACKNOWLEDEMENT TO SHARE INFORMATION WITH A HEALTH INFORMATION EXCHANGE:** I understand that Yoakum Family Practice participates in HASA, which is a nonprofit, community health information exchange that facilitates electronic exchange of patient information with physicians, hospitals, labs, pharmacies, and other providers. HASA will also connect to other HIEs to allow information to be available to other providers when patients travel outside of their region. Sharing patient information with other providers through HASA helps Yoakum Family Practice save patient's time and make better treatment decisions with a more complete patient record. I can opt-out of HASA at any time by requesting an opt-out form from Yoakum Family Practice. More information about HASA can be found at www.hasatx.org.

**I have read each of the statements above and authorize, understand, and agree to each statement.**

| **Patient's Signature:** | **Date:** |
|---|---|
| **Patient Name (please print):** | |

Yoakum Family Practice
at Yoakum Community Hospital

## NOTICE REGARDING YOUR LAB WORK

It has come to our attention that several insurance companies are denying Lab Tests that are drawn in our office and sent to an outside lab. It may be to your best interest to contact your insurance company before having your lab drawn. You will be responsible for charges that are denied by your insurance company.

_____ _____

Patient's Printed Name Date

_____

Signature of Patient or Responsible Party

## FINANCIAL POLICY

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept all major credit cards.

### Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment and are due at the time of service.
- In the event that your health plan (Medicare/Medicaid/Commercial insurance) determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- Prior arrangements will need to be made with our office for all worker's compensation claims. We only file claims for specific providers within our practice and only to insurance companies with whom we are in-network with.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

**I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.**

_____ _____

Patient's Printed Name Date

_____

Signature of Patient or Responsible Party

Yoakum Family Practice
at Yoakum Community Hospital

## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

**Home Telephone**_____

☐ Leave message with detailed information

☐ Leave message with call-back number only

**Written Communication:**

☐ Mail to my home address

☐ Mail to my work/office address

☐ Fax to this number _____

**Work Telephone**_____

☐ Leave message with detailed information

☐ Leave message with call-back number only

## RELEASE OF HEALTH INFORMATION AND/OR RECORDS

☐ **I authorize the release of my health information and/or records. This information may be released to the following individual(s):**

Name: _____
Relationship:_____
Phone Number:_____

Name: _____
Relationship:_____
Phone Number:_____

This ***Release of Health Information and/or Records*** will remain in effect until terminated by me in writing.

☐ **My health information and/or records are not to be released to anyone.**

_____
Patient's Printed Name

_____
Date

_____
Signature of Patient or Responsible Party

_____
Birthdate

Yoakum Family Practice
at Yoakum Community Hospital

# CONSENT FORM FOR ePRESCRIBE PROGRAM

## ePrescribe Program

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

**Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
**Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
**Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Yoakum Family Practice as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS.
***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information*.**

## Consent

1. Prescription refill policy – It is the policy of Yoakum Family Practice that medication refills will be processed within two business days (no weekends or holidays) of receipt of the request.
2. By signing this consent form you are agreeing that your provider at Yoakum Family Practice may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.
3. You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.
4. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

**Understanding all of the above, I hereby provide informed consent to Yoakum Family Practice to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.**

_____ _____
Patient's Printed Name Date

_____ _____
Signature of Patient or Responsible Party Birthdate

Yoakum Family Practice
at Yoakum Community Hospital

# PATIENT PORTAL TERMS AND CONDITIONS AGREEMENT

Yoakum Family Practice provides a patient portal through a third party vendor for the exclusive use of its patients. The patient portal is designed to enhance the ability of our patients to view a limited portion of their confidential patient information. All users must be established through registration as a Yoakum Family Practice patient. The patient portal is provided as a courtesy to our patients. However, if abuse or negligent usage of patient portal persists, we reserve the right at our own discretion to terminate patient portal offering, suspend user access, or modify services offered through the patient portal.

## Guidelines and Security

Yoakum Family Practice offers secure viewing of limited health information to our patients who wish to view parts of their records online. The patient portal is provided through a third party vendor on a HIPAA compliant VPN with encryption that meets HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. All new and established patients have signed and have been offered a copy of our HIPAA Notice of Privacy Practice. If you do not recall having signed the HIPPA Notice of Privacy or need to reacquaint with our policy, a copy can be provided to you for your review. This patient portal is a valuable tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. By providing Yoakum Family Practice with your e-mail address you accept the risks and agree to the conditions of participation. Once your email is provided and the Patient Portal Terms and Conditions Agreement is signed you will receive an email notification that instructs you how to log in for the first time. Please keep this email in a safe place for future reference. Following the instructions on the email, you should be able to log in using the link received in the initial email.

## Registration

You agree that the information that you provide upon registration to use the Patient Portal and at all other times will be true, accurate, current, and complete. You also agree that you will ensure that this information is kept accurate and up to date at all times. In particular, you must keep your e-mail address up to date. If you change your mind and wish to opt out of the Portal, you must contact us at Yoakum Family Practice. We are unable to opt out of the Portal over the phone.

## User ID and Password

When you register, you will be asked to provide a password. Since you will be responsible for all of the activities that occur with respect to your User Account, we ask that you keep your password confidential. Your Account is solely for your personal use, and you shall not authorize others to use your User Account, including your profile or email address. You must notify us of any unauthorized use of your password or if you believe that your password is no longer confidential.

## Emergency-related Questions via the Patient Portal

The Patient Portal is not to be used for emergency related health care issues. Please call Yoakum Family Practice directly with any question that you would like answered within 24 hours. If you are experiencing a health care emergency, call 911 or visit the nearest emergency room.

## PATIENT PORTAL TERMS AND CONDITIONS AGREEMENT (CONTINUED)

**Patient Portal Limitation of Liability**

To the fullest extent allowed by law, in no event shall Yoakum Family Practice (or any of its officers, directors, shareholders, employees, agents, representatives, successors and assigns) have any liability to you for any indirect, special, incidental, exemplary, punitive or consequential damages whether arising in contract, equity, negligence, intended conduct, or otherwise (including breach of warranty, negligence, gross negligence, willful misconduct, and strict liability in tort), including, without limitation, damages arising from delay, loss of goodwill, loss of or damage to data, lost profits, revenue or savings (actual or anticipated), or other economic loss or lost profits in connection with or ensuing from (I) the use or inability to use the patient portal, (II) any transactions conducted through or facilitated by the patient portal, including any offers or incentives realized by you through your use of the patient portal; (III) any claim attributable to errors, omissions, or other inaccuracies in the patient portal, (IV) any unauthorized access to or alteration of your transmissions or data, or (V) any other matter related to the patient portal or any content or information provided on the patient portal, even if one has been advised of the possibility of such damages.

I have read and fully understand this consent. I understand the risks associated with online communications. By checking "I accept" below I intend to sign this consent, I hereby give my informed consent to participate in the patient portal, and I hereby agree to and accept all of the provisions contained above. A copy of this agreement will be included in my medical record.

Indicate your acceptance to be bound by the terms of this agreement by checking "I Accept" below and following the other instructions in the registration process.

**If you choose not to become a member of the portal check "I Do Not Accept"**

- ☐ **I Accept - Patient email address:**_____
- ☐ **I Do Not Accept or Choose to Opt Out**

_____ _____

Signature of Patient/Parent/Conservator/Guardian Date/Time

_____

Printed Name

_____

Authority/Relationship to Patient

_____

Witness

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code 32.003).

_____ _____

Signature of Minor Date

Yoakum Family Practice
at Yoakum Community Hospital

## Acknowledgement to Share Information with a Health Information Exchange

Yoakum Family Practice participates in HASA, which is a nonprofit, community health information exchange that facilitates electronic exchange of patient information with physicians, hospitals, labs, pharmacies, and other providers. HASA will also connect to other HIEs to allow information to be available to other providers when patients travel outside of our region. Sharing patient information with other providers through HASA helps Yoakum Family Practice save patients' time and make better treatment decisions with a more complete patient record. It will allow them to avoid duplicate tests and procedures and gain immediate access in emergencies to critical information like allergies, diagnosis, medications, and other important data. Patients can also read more about HASA at www.hasatx.org.

I understand that Yoakum Family Practice shares patient information through HASA and have received a copy of HASA's brochure.

I understand I can opt-out of HASA at any time by requesting an opt-out form from Yoakum Family Practice or by downloading an opt-out form at www.hasatx.org/forms and providing it to Yoakum Family Practice.

## Acknowledgement of Receipt of Patient Portal FAQ's and Information Regarding Use of 3rd Party Apps to Import Health Information

A patient portal is a secure online website that gives you convenient 24-hour access to your personal health information and medical records called an Electronic Health Record or EHR from anywhere with an Internet connection. Yoakum Family Practice provides access to a patient portal through Athenahealth with the ability to connect 3rd party apps to import health information through an API.

I acknowledge I have received a copy of Yoakum Family Practice's Patient Portal frequently asked questions along with information regarding patient's availability and use of 3rd party apps to import health information.

**I have read each of the statements above and authorize, understand, and agree to each statement.**

| **Patient's Signature:** | **Date:** |
|---|---|
| **Patient Name (please print):** | |

Yoakum Family Practice
at Yoakum Community Hospital
1200 Carl Ramert Drive, Suite D
Yoakum, TX 77995
P: 361.293.7061
F: 361.293.6559

# CONSENT TO RELEASE MEDICAL INFORMATION

1. **I hereby authorize:**

   Previous provider name and/or clinic name:_____

   Previous provider address:_____

   Previous provider phone number:_____

   **To release the following heath care records of:**

   Patient name:_____

   Patient address:_____

   Patient SSN:_____ Patient DOB:_____

2. **Information to be released:**

   ☐ Copy of complete medical records
   ☐ History and physical
   ☐ Including information related to HIV testing and/or results
   ☐ Other: _____

3. **Information to be released to:** _____

4. **Purpose of disclosure:**_____

5. **Specification of the date, event or condition upon which the consent expires:**_____

   _____

**I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The facility, its employees, officers, and providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.**

_____ _____
Patient/Guardian Signature Date

_____
Relationship to Patient

_____ _____
Witness Date

Yoakum Family Practice
at Yoakum Community Hospital

**WELCOME TO OUR PRACTICE**

**Date:**_____

**Name:**_____

**Address:**_____

**City/Zip:**_____

**Appointment Date & Time:**_____

We are pleased that you have chosen us for all your healthcare needs. Attached you will find the required paperwork for your appointment. Please complete all the paperwork and return it at your appointment time, for this will reduce waiting time. There is also a check list in this packet for more information that is also needed.

**Please bring the following with you to your appointment:**

1. All paperwork completed
2. All medication presently taking
3. Driver's license
4. Insurance cards (medicare/medicaid/commercial)
5. Immunization record for children (shot record
6. Payment for your services (private pay/co-pay/deductible)

Thank you in advance!

Yoakum Family Practice